| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| POC#2 | 445373 | A. BUILDING _____ B. WING _____ | 11/30/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C | 202 EAST MTCS ROAD MURFREESBORO, TN 37130 |

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|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>A recertification survey and complaint investigation #42717, #42878, #42882, #42907, #42910 were completed on 11/28/17-11/30/17 at Northside Health Care Nursing and Rehabilitation Center. No deficiencies were cited related to complaint investigation #42717, #42907, and #42910. Deficiencies were cited related to the recertification survey and complaint investigations #42878 and #42882 under 42 CFR PART 483, Requirements for Long Term Care Facilities. | F 000 | This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements and state requirements when necessary<br><br>**F550**<br><br>1.<br>a. Residents #15 was offered appropriate utensils during meal times and offered assistance periodically throughout meal on 11/30/17.<br>b. All residents (including 16 and 35) requiring assistance were ensured to be assisted timely by adding 2 additional staff members to assist with meals as of 11/30/17.<br>2. DON and ADON did 100% audit of residents in the dining area<br>3. All nursing staff will be re-educated on Resident Rights and Dining Services policies by 12/29/17. New Employees will be educated upon hire before entering patient care areas.<br>4. DON, ADON, and other designee to do 2x weekly audits of dining areas and dining practices for 6 weeks. Any findings of noncompliance will be presented to the QAPI committee for review. | 11/30/17<br><br>11/30/17<br><br>12/29/17<br><br>01/26/18 |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights. | F 550 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Erika Calde, LNHA — TITLE: Administrator — (X6) DATE: 12/15/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 12/05/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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|---|---|---|---|---|
| F 550 | Continued From page 1 | F 550 | | |

The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to preserve the dignity of residents who required feeding assistance for 3 residents (#15, #16, #35) of 23 residents observed for dining.

The findings included:

Medical record review revealed Resident #15 was admitted to the facility on 3/3/16 with diagnoses including Diabetes Mellitus, Paroxysmal Atrial Fibrillation, Obstructive Sleep Apnea, and Fibromyalgia.

Medical record review of the Quarterly Minimum Data Set (MDS) dated 9/2/17 revealed Resident #15 scored 10 on the Brief Interview for Mental Status (BIMS), indicating she had moderate cognitive impairment. Continued review of the MDS revealed Resident #15 was dependent for transfers and bathing; required extensive assistance with dressing, grooming, eating, and toileting.

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OMB NO. 0938-0391

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|---|---|---|---|---|
| F 550 | Continued From page 2 | F 550 | | |

Observation on 11/28/17 at 12:42 PM revealed Resident #15 was unable to eat her pudding due to not having a spoon so she licked the pudding out of the bowl. Continued observation revealed she spilled pudding on her clothing and had it smeared on her face. Several staff members passed by Resident #15 and failed to offer assistance.

Medical record review revealed Resident #16 was admitted to the facility on 9/17/15 with diagnoses including Parkinson's Disease, Chronic Pain, Dementia, and Transient Ischemic Attack.

Medical record review of the Quarterly MDS dated 9/4/17 revealed Resident #16 was severely impaired cognitively. Continued review of the MDS revealed Resident #16 was dependent on 2 people for transfers; was dependent on one person for dressing, eating, grooming, and bathing.

Observation on 11/28/17 at 11:30 AM revealed Resident #16 was seated at table for 4 who required feeding assistance. The Certified Nurse Aide (CNA) fed one resident at a time. Resident #16 was the last to be assisted with eating; the food was uncovered while other residents were assisted with eating; the food was not reheated before she was assisted with eating.

Observation on 11/29/17 at 8:10 AM revealed Resident #16 was seated at a table. The CNA assisted one resident at a time. Resident #16 was the last to be assisted with eating and was sleepy. Observation revealed the food remained uncovered while 3 other residents were assisted with eating and was not reheated. Continued

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| | 445373 | A. BUILDING _____ B. WING _____ | 11/30/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 550 | Continued From page 3 | F 550 | | |

observation revealed the CNA sat in front of Resident #16 and put a spoon of food in the resident's mouth without saying anything to her. Further observation revealed Resident #16 was not waking up so the CNA assisted her with 3 bites then moved on to another resident.

Medical record review revealed Resident #35 was admitted to the facility on 7/20/15 with diagnoses including Alzheimers, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease.

Medical record review of the Quarterly MDS dated 4/10/17 revealed Resident #35 was severely impaired cognitively. Continued review of the MDS revealed Resident #35 required extensive assistance with transfers, dressing, grooming, bathing, eating, and toileting.

Observation on 11/28/17 at 12:30 PM, revealed the lunch tray was placed on the table at 11:30 AM. Resident #35 did not eat until her son came to assist her with eating at 12:10 PM. Observation revealed the food was not reheated before the resident was assisted with eating.

Observation on 11/29/17 at 8:00 AM revealed breakfast trays arrived at 8:00 AM. Resident #35 was assisted with eating at 8:22 AM after 2 other residents were assisted.Continued observation revealed the food was not reheated before the resident was assisted with eating.

Interview with the Director of Nursing (DON) on 11/30/17 at 1:50 PM in her office confirmed it was not acceptable to fail to assist a resident who has food on their face and clothing. Continued interview with the DON confirmed residents should not be made to wait for their meals and

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|---|---|---|---|
| | 445373 | A. BUILDING _____ B. WING _____ | 11/30/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 550 | Continued From page 4<br>the food should be reheated before assisting the resident. | F 550 | F561 | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to allow 1 resident (#11) of 26 residents observed the right to determine where and with | F 561 | 1. Resident # 11 was moved to another table of her choice on 11/29/17. — 11/29/17<br>2. Social Worker and Activities interviewed 100% of alert and oriented residents in the dining room about their setting preferences on 11/29/17. — 11/29/17<br>3. All staff will be re-educated on the importance of Resident Choice by 12/29/17. Social Services, Dietary, and Activities will interview all residents able to be interviewed to update preferences by 12/29/17. Dietary preference tool will be updated to reflect dietary seating preference by 12/13/17. — 12/29/17<br>4.<br>a. CDM, Dietician and other designee to do 2x weekly audits of dining areas and dining practices for 6 weeks. — 01/26/18<br>b. Social Services, Dietary, and Activities to interview 3 residents (1 resident each) a week for 6 weeks to ensure preferences are being met.<br><br>Any findings of noncompliance will be presented to the QAPI committee for review. | |

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OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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|---|---|---|---|
| | 445373 | A. BUILDING _____ B. WING _____ | 11/30/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 561 | Continued From page 5<br>whom to dine with during breakfast and lunch.<br><br>The findings included:<br><br>Observation on 11/28/17 from 11:25 AM-12:05 PM in the main dining room revealed Resident #11 was seated at a table alone eating the lunch meal. Continued observation revealed she had no interaction with staff or other residents.<br><br>Observation on 11/29/17 from 7:30 AM-8:05 AM revealed Resident #11 was seated at a table alone eating breakfast. Continued observation revealed she had no interaction with staff or other residents.<br><br>Interview with Resident #11 on 11/29/17 at 8:07 AM in the main dining room when asked why she was at a table all alone stated, "I guess nobody wants to sit with me." Continued interview confirmed the resident would like to sit with other residents during dining.<br><br>Interview with the Activities Director on 11/29/17 at 8:10 AM in the main dining room when asked why Resident #11 was seated alone for dining stated, "She used to sit with someone but the lady died." Continued interview revealed the facility used a seating chart for the residents "so we can deliver the trays at one time to each table." Further interview confirmed the facility failed to offer Resident #11 the choice to sit with other residents for social interaction during dining. | F 561 | | |
| F 584 SS=D | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, | F 584 | | |

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| | 445373 | A. BUILDING _____ B. WING _____ | 11/30/2017 |

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|---|---|---|---|---|
| F 584 | Continued From page 6<br>comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by: | F 584 | F584<br><br>1. Resident #9's wheelchair was cleaned to remove debris and sanitized for infection control on 11/30/17.<br>2. 100% Audit of all wheelchairs throughout the building and they were cleaned and sanitized as needed on 12/13/17.<br>3. All staff will be re-educated on Resident's Rights and the importance of a clean, homelike environment. Staff will also be educated on a revised cleaning schedule on 12/13/17.<br>4. Audits of resident areas and equipment to be completed 5x a week by the management team during Guardian Angel Rounds for 6 weeks. Any findings of noncompliance will be presented to the QAPI committee for review. | 11/30/17<br><br>12/13/17<br><br>12/13/17<br><br>01/26/18 |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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|---|---|---|---|
| | 445373 | A. BUILDING _____ B. WING _____ | 11/30/2017 |

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|---|---|---|---|---|
| F 584 | Continued From page 7 | F 584 | | |

Based on observation and interview, the facility failed to maintain a wheelchair in a sanitary manner for 1 resident (#52) of 37 residents reviewed.

The findings included:

Observation on 11/28/17 at 9:14 AM revealed Resident #9 seated in a wheelchair in the doorway of his room. Further observation revealed the left side of the wheel chair frame had multiple areas of dried brown debris.

Observation on 11/28/17 at 11:09 AM, on 11/29/17 at 11:00 AM, and on 11/30/17 at 11:20 AM revealed Resident #9 seated in a wheelchair in the main dining room at the dining room table. Further observation revealed the left side of the wheelchair frame had multiple areas of dried brown debris.

Interview with Licensed Practical Nurse #2 on 11/30/17 at 11:21 AM by Resident #9's wheelchair in the main dining room confirmed the wheel chair "...was dirty...That's disgusting..."

Interview and observation with the Director of Nursing on 11/30/17 at 2:05 PM in Resident #9's room revealed the wheelchair was stored in the resident's bathroom while the resident was in bed. Further interview revealed the wheelchair cleaning was done by rotation on the night shift and Resident #9's was scheduled for Sunday night. Further interview revealed the staff transferring a resident out of the wheelchair should wipe it down if it was dirty. Interview confirmed the dried brown debris on the cushion seat, under the cushion and along the left side of the frame was "Not acceptable."

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|---|---|---|---|---|
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of facility policy, medical record review, review of an Investigation Summary, and interview, the facility failed to prevent resident-to-resident abusive behaviors between 2 residents (#11 and #37) of 13 residents reviewed.<br><br>The findings included:<br><br>Review of facility policy, Abuse, Neglect, Exploitation, effective 1/27/2016 revealed "...each resident has the right to be free from abuse..."<br><br>Medical record review revealed Resident #11 was admitted 4/28/10 and readmitted 6/9/17 with diagnoses including Chronic Obstructive Pulmonary Disease, Asthma, Vascular Dementia without Behaviors and with Delusions, Insomnia, Generalized Anxiety Disorder, Paranoid Schizophrenia, Major Depressive Disorder, Atrial Fibrillation, Hypertension, Arteriosclerotic Heart | F 600 | F600<br><br>1. Residents #11 and #37 were immediately separated and assessed for injuries. No Injuries were found.<br>a. Resident #37s Responsible Party and doctor were notified on 11/6/17. Resident #37 was also sent to ER to be evaluated for psychiatric treatment<br>b. Resident #11s Responsible Party and doctor were notified on 11/6/17.<br>2. DON and ADON interviewed staff involved in altercation about any other potential altercations that may have happened. Nursing Staff on duty continued to monitor all other residents for any potential altercations. Social Worker interviewed and observed residents to see if they had any reports or actions of altercations.<br>3. All staff were re-educated on the abuse policy starting on 11/7/17. New employees are educated on abuse policies including patient to patient altercations prior to entering patient care environment.<br>4. Social Services to interview 3 residents weekly for any concerns of abuse for 6 weeks. Management team will also ask residents during Guardian Angel Rounds if they have any concerns of abuse. Any findings of noncompliance will be presented to the QAPI committee for review. | 11/6/17<br><br>11/6/17<br><br>11/7/17<br><br>1/24/18 |

PRINTED: 12/05/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| | 445373 | A. BUILDING _____ B. WING _____ | 11/30/2017 |

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|---|---|---|---|---|
| F 600 | Continued From page 9 | F 600 | | |

Disease, Cardiac Arrhythmia, Diabetes Mellitus Type II, Anemia, Gastroesophageal Reflux Disease, Difficulty Walking/Muscle Weakness, and status-post Right Total Hip Replacement. Continued medical record review revealed a quarterly Minimum Data Set (MDS) dated 11/10/17 revealed severe cognitive impairment with no moods or behaviors exhibited.

Medical record review revealed Resident #37 was admitted 4/7/16 with diagnoses including Cerebral Infarction due to Left Mid-Cerebral Artery Occlusion with Right-sided Hemiplegia and Aphasia, Dementia, Schizoaffective Disorder-Depressive Type, Anxiety Disorder, Major Depressive Disorder, Gastroesophageal Reflux Disease, Hypertension, Atherosclerosis, Hypokalemia, Hypercholesterolemia, Dysphagia, Low Vision Right Eye, Diabetes Mellitus Type II, and Lymphedema with Cellulitis of the Right Lower Extremetiy. Continued medical record review revealed a quarterly MDS dated 10/6/17 revealed moderate cognitive impairment with poor decision making.

Review of an Investigation Summary dated 11/6/17 at 10:00 AM revealed Resident #37 was in his wheelchair propelling in the 300 hall toward the dining room while Resident #11 was in her wheelchair propelling in the 300 hall away from the dining room and directly in the path of Resident #37. Resident #37 made an obscene gesture toward Resident #11 to move from his path and when Resident #11 did not move, Resident #37 slapped her left arm. Continued review revealed Licenced Practical Nurse (LPN) #3 observed the event and separated Resident #11 and #37; Certified Nurse Aide (CNA) #2 was slapped and received an obscene gesture by

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 445373 | A. BUILDING _____ B. WING _____ | 11/30/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C | 202 EAST MTCS ROAD MURFREESBORO, TN 37130 |

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| F 600 | Continued From page 10 | F 600 | | |

Resident #37 when attempting to take him toward his room. Continued review revealed Resident #37 was transferred to an emergency department for medical evaluation, clearance, and possible placement in a psychiatric facility.
Continued review revealed Resident #11 sustained a slight discoloration to the left mid-forearm.

Medical record review of a Nurse's Note dated 11/2/17 at 6:20 AM revealed Resident #37, was spitting and making obscene gestures toward staff when he learned he might be getting a roommate. Continued review of a Nurse's Note dated 11/3/17 at 12:10 PM revealed Resident #37 refused his medications and care relating to a possible new roommate. Continued review of the Nurse's Notes dated 11/6/17 at 3:21 PM and 3:46 PM respectively revealed a "physical altercation with another resident" had occurred and CNA #2, "was hit on the arm by resident [#37]."

Interview with CNA #2 on 11/30/17 at 10:40 AM in the 300 hall revealed Resident #37 hit and made an obscene gesture toward Resident #11 on the left arm for not getting out of his way. Continued interview revealed CNA #2 helped take Resident #37 back to his room and he made an obscene gesture toward CNA #2 and "...hit my arm...."

Interview with LPN #1 on 11/30/17 at 10:45 AM in the 300 hall revealed Resident #37 was upset about the possibility of getting a roommate and "acted-out by hitting at others."

Interview with the Social Services Director on 11/30/17 at 1:35 PM in her office revealed Resident #37 was upset at the possibility of getting a roommate and this "probably triggered"

PRINTED: 12/05/2017
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| F 600 | Continued From page 11<br>him to act out.<br><br>Interview with the Director of Nursing (DON) on 11/30/17 at 1:45 PM in her office confirmed Resident #37 was triggered by the possibility of getting a roommate and slapped Resident #11. Continued interview confirmed the facility failed to prevent abusive behaviors of Resident #37 towards Resident #11. | F 600 | | |
| F 602 SS=D | Free from Misappropriation/Exploitation<br>CFR(s): 483.12<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy review, medical record review, and interview, the facility failed to prevent misappropriation of controlled medications for 1 resident (#37) of 37 residents reviewed.<br><br>The findings included:<br><br>Review of facility policy, Abuse, Neglect, Exploitation, dated 11/27/16, revealed "...Misappropriation of resident property means deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent...When a suspicion occurs an investigation is immediately warranted...Ensure alleged violations are reported immediately..." | F 602 | **F602**<br><br>1.<br>a. LPN #4 was terminated on 11/2/17. She did not work any hours from the time she clocked out on the morning of 11/1/17. LPN #4 was also presented to the board of nursing on 11/3/17. — 11/2/17<br>b. Resident #37 was assessed for any adverse effects, none were found. Resident #37s Responsible Party and Doctor were both notified on 11/1/17. — 11/1/17<br>2. DON and ADON completed 100% audit of 200/300 wing med cart to include narcotics that LPN #4 had access to on 11/1/17. — 11/1/17<br>3. All nursing staff was re-educated on appropriate handling and dispensing of medications policy starting on 11/1/17. New employees are now educated on same policy upon hire prior to administering medications. — 11/1/17<br>4. DON or designee will conduct random audits of the resident's medication to ensure that they have been administered per order. Any discrepancies will be verified with MAR documentation. These audits will be conducted on 5 random residents 2x a week for 6 weeks and random thereafter to ensure compliance. Any findings of noncompliance will be presented to the QAPI committee for review. — 01/26/18 | |

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| F 602 | Continued From page 12 | F 602 | | |

Review of facility policy, Controlled Medication Policy, effective 11/28/17 revealed "...The facility will have safeguards in place to prevent loss, diversion, or accidental exposure...Any discrepancies that cannot be resolved must be reported immediately: notify the DON immediately and the Pharmacy; complete an investigation detailing the discrepancy; steps taken to resolve it; and names of all licensed staff working when the discrepancy was noted...Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies..."

Medical record review revealed Resident #37 was admitted to the facility on 4/7/16 with diagnoses including Cerebrovascular Accident with Right Hemiplegia, Aphasia, Diabetes Mellitus, Hypertension, Gastroesophageal Reflux Disease, Seizures, and Arteriosclerotic Cardiovascular Disease.

Medical record review of the Quarterly Minimum Data Set (MDS) dated 10/6/17 revealed Resident #37 was moderately impaired cognitively.

Medical record review of the October Medication Administration Record (MAR) and Narcotic Sign-Out Record revealed on 10/30/17 and 10/31/17 Ativan (antianxiety) 0.5 milligrams (mg) were signed out and 0.25 mg were wasted each night.

Review of the facility investigation revealed the narcotic sign-out sheet for Ativan for Resident #37 had the signature of Licensed Practical Nurse (LPN) #4 as administering the medication but also had the signature of Registered Nurse (RN) #2 as observing/confirming the wasting of

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| F 602 | Continued From page 13<br>0.25 mg of Ativan on 10/30/17 and 10/31/17. Continued review revealed the signature did not appear to be that of RN #2 and when questioned she denied it was her signature.<br><br>Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 11/30/17 at 1:50 PM in their office revealed LPN #4 signed out Ativan on 10/30/17 and again on 10/31/17. Continued interview revealed the dose of Ativan signed out was 0.5 mg and the order was for 0.25 mg so 0.25 mg was wasted each night. Further interview revealed the signature of the nurse observing and confirming the wastage appeared to be RN #2 but the DON and ADON said it was not her regular signature. Continued interview revealed RN #2 was interviewed and categorically denied it was her signature. Further interview the DON confirmed the facility failed to prevent misappropriation of medications. | F 602 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other | F 609 | | |

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| F 609 | Continued From page 14<br>officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy review, medical record review, review of an Investigation Summary, and interview, the facility failed to timely report resident-to-resident abusive behaviors between 2 residents (#11, #37) of 13 residents reviewed<br><br>The findings included:<br><br>Review of facility policy, Abuse, Neglect, Exploitation, effective 1/27/2016 revealed "...Report allegations or suspected abuse...immediately to [the] Administrator...Other Officials in accordance with State Law...State Survey and Certification agency through established procedures..."<br><br>Medical record review revealed Resident #11 was admitted 4/28/10 and readmitted 6/9/17 with diagnoses including Chronic Obstructive Pulmonary Disease, Asthma, Vascular Dementia without Behaviors and with Delusions, Insomnia, Generalized Anxiety Disorder, Paranoid Schizophrenia, Major Depressive Disorder, Atrial Fibrillation, Hypertension, Arteriosclerotic Heart | F 609 | F609<br><br>1. Resident #11 and #37 RESPONSIBLE PARTY and MD were notified of the event. Residents were assessed and no injury found.<br>2. Administrator reviewed previous incident reports to ensure they were reported timely and correctly.<br>3. Management staff was re-educated on the regulation and timely reporting on 12/14/17. All staff will be re-educated on proper verbal notification to ensure accurate description of events by 12/29/17.<br>4. A member of the interdisciplinary team will review event notes five days a week to ensure documentation matches what is verbally reported. Weekly audits of all incidents will be reviewed for any trends and needed education for 6 weeks then monthly thereafter. All audits will be brought to QAPI for review. | 11/1/17<br><br>12/14/17<br><br>12/29/17<br><br>01/26/18 |

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| F 609 | Continued From page 15 | F 609 | | |

Disease, Cardiac Arrhythmia, Diabetes Mellitus Type II, Anemia, Gastroesophageal Reflux Disease, Difficulty Walking/Muscle Weakness, and status-post Right Total Hip Replacement. Continued medical record review revealed a quarterly Minimum Data Set (MDS) dated 11/10/17 revealed severe cognitive impairment with no moods or behaviors exhibited.

Medical record review revealed Resident #37 was admitted 4/7/16 with diagnoses including Cerebral Infarction due to Left Mid-Cerebral Artery Occlusion with Right-sided Hemiplegia and Aphasia, Dementia, Schizoaffective Disorder-Depressive Type, Anxiety Disorder, Major Depressive Disorder, Gastroesophageal Reflux Disease, Hypertension, Atherosclerosis, Hypokalemia, Hypercholesterolemia, Dysphagia, Low Vision Right Eye, Diabetes Mellitus Type II, and Lymphedema with Cellulitis of the Right Lower Extremetiy. Continued medical record review revealed a quarterly MDS dated 10/6/17 revealed moderate cognitive impairment with poor decision making.

Review of an Investigation Summary dated 11/6/17 at 10:00 AM revealed, "...Altercation was observed by employee #1 [Licensed Practical Nurse (LPN) #3] at around 10:00 AM on 11/6/17..."

Interview with Certified Nurse Aide (CNA) #2 on 11/30/17 at 10:40 AM in the 300 hall revealed Resident #37 hit and made an obscene gesture to Resident #11 on the left arm for not getting out of his way. Continued interview revealed CNA #2 stated the event happened on 11/6/17 at around 10:00 AM.

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| F 609 | Continued From page 16<br>Interview with LPN #1 on 11/30/17 at 10:45 AM in the 300 hall revealed Resident #37 was upset about the possibility of getting a roommate and "acted-out." Continued interview revealed LPN #1 stated Resident #37 slapped Resident #11 on 11/6/17 close to 10:00 AM.<br><br>Interview with the Social Services Director on 11/30/17 at 1:35 PM in her office revealed Resident #37 was upset at the possibility of getting a roommate and this "probably triggered" him to act out. Continued interview revealed the event occurred on 11/6/17 around 10:00 AM.<br><br>Interview with the Director of Nursing (DON) on 11/30/17 at 1:45 PM in her office confirmed the event between Resident #11 and #37 occurred 11/6/17 around 10:00 AM and the facility failed to timely report the occurrence to the State Agency until 11/7/17 at 11:18 AM. | F 609 | | |
| F 641<br>SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and interview, the facility failed to accurately assess vision for 1 resident (#44) of 37 residents reviewed.<br><br>The findings included:<br><br>Medical record review revealed Resident #9 was readmitted to the facility on 6/7/17 with diagnoses including Legally Blind. | F 641 | F641<br>1. MDS for Resident #9 was corrected by MDS to reflect that the resident's vision is severely impaired/blind on 11/30/17. — 11/30/17<br>2. A 100% audit of current residents and latest MDS vision assessment to ensure accurate coding on 12/14/17. — 12/14/17<br>3. The administrator provided a Coaching Form to the Social Service Director on the RAI manual standards for vision coding on 12/13/17. — 12/13/17<br>4. MDS coordinator to audit random (at least 3) Social Services completed sections prior to submitting to ensure accurate coding weekly for 6 weeks. Any findings of noncompliance will be presented to the QAPI committee for review. — 01/26/18 | |

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| F 641 | Continued From page 17<br>Medical record review of the Quarterly Minimum Data Set (MDS) dated 10/24/17 revealed Resident #9's vision was adequate.<br><br>Interview with the MDS Coordinator on 11/30/17 at 8:42 AM in her office regarding the 10/24/17 vision MDS assessment revealed the Social Worker was responsible for the vision assessment on the MDS. Further interview confirmed vision was inaccurately assessed as adequate instead of severely impaired/blind.<br><br>Interview with the Social Worker on 11/30/17 at 8:47 AM in the MDS office confirmed she was responsible for the vision assessment on the MDS Further interview confirmed Resident #9 should have been classified as highly impaired and the MDS was not accurate. | F 641 | | |
| F 675 SS=D | Quality of Life<br>CFR(s): 483.24<br><br>§ 483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and medical record review, the facility failed to correctly position 1 resident (#3) of 9 residents in mobility devices in the dining room. | F 675 | | |

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| F 675 | Continued From page 18<br>The findings included:<br><br>Observation on 11/29/17 at 8:20 AM in the dining room revealed Resident #3 was dependent for assistance with meals and seated at a restorative table in a broda chair (specialized large wheelchair). Continued observation revealed the resident was positioned in a 45 degree angle and was being assisted with eating by a Certified Nurse Aide (CNA).<br><br>Interview with the CNA #3 on 11/29/17 at 8:20 AM in the dining room confirmed Resident #3 was positioned in a 45 degree angle while being assisted with eating the breakfast meal. Continued interview revealed the CNA stated Resident #3 would try to get out of the chair during meals, or hit staff that assisted her. Continued interview confirmed the facility failed to correctly position Resident #3 during assistance with eating.<br><br>Interview with the Assistant Director of Nursing on 11/30/17 at 1:30 PM in her office confirmed staff had been trained on how to assist residents with eating during meals. Continued interview confirmed the facility failed to accurately position Resident #3 while assisting with eating. | F 675 | F675<br><br>1. Resident #3 was sat up into the proper position for eating during all meals starting on 11/30/17. — 11/30/17<br>2. 100% audit of all residents in mobility devices during dining times was done on 12/1/17. — 12/1/17<br>3. All nursing staff will be re-educated on Resident Rights and Dining Services policies by 12/29/17. New Employees will be educated upon hire before entering patient care areas. — 12/29/17<br>4. DON, ADON, and other designee to do 2x weekly audits of dining areas and dining practices for 6 weeks. Any findings of noncompliance will be presented to the QAPI committee for review. — 01/26/18 | |
| F 684 SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of | F 684 | | |

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| F 684 | Continued From page 19<br>practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of facility policy, medical record review, review of a facility investigation, and interview, the facility failed to ensure medications were administered according to Physician Orders and narcotics were wasted according to facility policy for 6 residents (#6, #8, #15, #24, #35, #37) of 37 residents reviewed.<br><br>The findings included:<br><br>Review of facility policy, Preventing Medication Errors and Medication Administration, effective 11/28/17, revealed "...Medications may only be administered by licensed medical or nursing personnel acting within the scope of their license as per the Physician order honoring resident choices and activities as much as possible, consistent with the person centered comprehensive care plan...Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescription order; the manufacturer's specifications regarding preparation and administration; accepted professional standards and principals which apply to professionals providing services..."<br><br>Review of facility policy, Controlled Medication Policy, effective 11/28/17, revealed "...The facility will have safeguards in place to prevent loss, diversion, or accidental exposure...Any discrepancies that cannot be resolved must be reported immediately: notify the DON immediately and the Pharmacy; complete an investigation detailing the discrepancy; steps taken to resolve | F 684 | F684<br>1.<br>a. LPN #4 was terminated on 11/2/17. She did not work any hours from the time she clocked out on the morning of 11/1/17. LPN #4 was also presented to the board of nursing on 11/3/17.<br>b. Residents # 6, 8,15,24,35, and 37 were assessed for any adverse effects, none were found. All of their families and Doctors were notified on 11/1/17.<br>2. DON and ADON completed 100% audit of 200/300 wing med cart to include narcotics that LPN #4 had access to on 11/1/17.<br>3. All nursing staff was re-educated on appropriate handling and dispensing of medications policy starting on 11/1/17. New employees are now educated on same policy upon hire prior to administering medications.<br>4. DON or designee will conduct random audits of the resident's medication to ensure that they have been administered per order. Any discrepancies will be verified with MAR documentation. These audits will be conducted on 5 random residents 2x a week for 6 weeks and random thereafter to ensure compliance. Any findings of noncompliance will be presented to the QAPI committee for review. | 11/2/17<br>11/1/17<br>11/1/17<br>01/26/18 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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| | 445373 | A. BUILDING _____ B. WING _____ | 11/30/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 684 | Continued From page 20 | F 684 | | |

it; and names of all licensed staff working when the discrepancy was noted...Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies..."

Medical record review revealed Resident #6 was admitted to the facility on 5/24/16 with diagnoses including Atherosclerotic Cardiovascular Disease, Hypertension, Gastroesophageal Reflux Disease, and Crohn's Disease.

Medical record review of the Quarterly Minimum Data Set (MDS) revealed Resident #6 scored 8 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment.

Medical record review of the Medication Administration Record (MAR) for October 2017 revealed it was documented Resident #6 was administered Tramadol (pain) 50 milligrams (mg) at 9:00 PM on 10/30/17 by Licensed Practical Nurse (LPN) #4.

Medical record review revealed Resident #8 was admitted to the facility on 6/3/16 with diagnoses including End Stage Renal Disease, Hypertension, Coronary Artery Disease, Cerebrovascular Accident, Dementia, and Deep Vein Thrombosis.

Medical record review of the Quarterly MDS dated 11/11/17 revealed Resident #8 scored 15 on the BIMS indicating she was alert, oriented, and able to make her needs known.

Medical record review of the October MAR revealed documentation Resident #8 was administered Melatonin 5 mg at 9:00 PM on 10/31/17.

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|---|---|---|---|---|
| F 684 | Continued From page 21 | F 684 | | |

Medical record review revealed Resident #15 was admitted to the facility on 3/3/16 with diagnoses including Diabetes Mellitus, Paroxysmal Atrial Fibrillation, Obstructive Sleep Apnea, and Fibromyalgia.

Medical record review of the Quarterly MDS dated 9/2/17 revealed Resident #15 scored 10 on the BIMS, indicating she had moderate cognitive impairment.

Medical record review of the October MAR revealed documentation Resident #15 was administered Atorvastatin 20 mg at 9:00 PM on 10/31/17.

Medical record review revealed Resident #24 was admitted to the facility on 5/3/99 with diagnoses including Congestive Heart Failure, Seizures, Diabetes Mellitus, Hypertension, and Benign Prostatic Hypertrophy.

Medical record review of the Quarterly MDS dated 9/14/17 revealed Resident #24 was severely impaired cognitively.

Medical record review of the October MAR revealed documentation Resident #24 was administered a Fentanyl (pain) patch 50 micrograms per hour to be changed every 3 days on 10/31/17.

Medical record review revealed Resident #35 was admitted to the facility on 7/20/15 with diagnoses including Alzheimers, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease.

Medical record review of the Quarterly MDS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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|---|---|---|---|---|
| F 684 | Continued From page 22 | F 684 | | |

dated 4/10/17 revealed Resident #35 was severely impaired cognitively.

Medical record review of the October MAR revealed documentation Resident #35 was administered Neurontin (pain) 100 mg at 9:00 PM on 10/31/17.

Medical record review revealed Resident #37 was admitted to the facility on 4/7/16 with diagnoses including Cerebrovascular Accident with Right Hemiplegia, Aphasia, Diabetes Mellitus, Hypertension, Gastroesophageal Reflux Disease, Seizures, and Arteriosclerotic Cardiovascular Disease.

Medical record review of the Quarterly MDS dated 10/6/17 revealed Resident #37 was moderately impaired cognitively.

Medical record review of the October MAR revealed documentation Resident #37 was administered Atorovastatin 40 mg at 9:00 PM on 10/31/17. Continued review of the MAR and Narcotic Sign-Out Record revealed on 10/30/17 and 10/31/17 Ativan (antianxiety) 0.5 mg were signed out and 0.25 mg were wasted each night.

Review of the facility investigation revealed staff spoke with the Director of Nursing (DON) the morning of 10/31/17 regarding concerns LPN #4 was not administering medications on the 7:00 PM - 7:00 AM shift. Continued review revealed the DON conducted a count of all medications due to be administered to residents on the 7:00 PM - 7:00 AM shift on 10/31/17. Further review revealed the staff stated medications were not administered on 10/31/17 and LPN #4 was frequently absent from the nurses' station and the

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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|---|---|---|---|---|
| F 684 | Continued From page 23 | F 684 | | |

building. Continued review revealed the DON recounted the medications on 11/1/17 and found discrepancies with medications for Residents #6, #8, #15, #24, #35, and #37. Further review revealed the medication count was the same on 11/1/17 as it was on 10/31/17, indicating the medications were not given. Continued review revealed the residents who had discrepancies received their medications from LPN #4. Further review revealed the narcotic sign-out sheet for Ativan for Resident #37 had the signature of LPN #4 as administering the medication but also had the signature of RN #2 as observing/confirming the wasting of 0.25 mg of Ativan on 10/30/17 and 10/31/17. Continued review revealed the signature did not appear to be that of RN #2 and when questioned she denied it was her signature.

Review of a written statement from CNA #7 dated 11/1/15 revealed at 10:15 PM a resident asked for his medications. Continued review revealed CNA #7 went to the car of LPN #4 and found her asleep with the car running

Review of a written statement by the Assistant Director of Nursing (ADON) dated 10/31/17 revealed one resident stated she had to ask for pain medications during the night and the nurse (LPN #4) made her feel insecure about the medications she was administering. Continued review revealed another resident stated she had to ask for her medications quite awhile after they were due and the nurse (LPN #4) appeared sleepy. Further review revealed this resident was concerned for those residents who could not ask for their medications.

Review of the facility investigation revealed the DON determined LPN #4 did not administer the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 684 | Continued From page 24 | F 684 | | |

medications but documented them as being administered. Continued review revealed the DON and ADON telephoned LPN #4 to notify her she was terminated.

Interview with the DON and ADON on 11/30/17 at 1:50 PM in their office revealed on 10/31/17 the CNAs came to them to say they did not think LPN #4 was administering medications to residents. At that point the DON counted the medications that would be administered on the 7:00 PM - 7:00 AM shift. On the morning of 11/1/17 the staff again stated they felt medications were not administered and they couldn't find LPN #4 most of the night. When residents would ask for medications she would say she had already given them. At one point during the night one of the CNAs had to knock on the car window of LPN #4 because she was asleep in the car. The DON did another count of medications on 11/1/17 and found all narcotics counts were correct. Sporadic drugs were documented as administered but the medications were still in the blister packs, indicating they were not administered. Both the DON and ADON viewed the video surveillance from the night of 10/31/17 and noted LPN #4 to be absent from the building for periods of time as well as in a camera blind spot which was the beauty shop. They also noted LPN #4 to be sleeping at the nurses' station. At this point they called LPN #4; informed her of the findings; and told her she was terminated. Interview with the DON confirmed LPN #4 documented medications as being administered but they were not.

In summary, on the nights of 10/30/17 and 10/31/17, LPN #4 documented medications for 6 residents as being administered when they were not as evidenced by the count remaining the

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| F 684 | Continued From page 25<br>same for both days. On those two nights LPN #4 signed out 2 narcotics; wasted part of the tablet; and signed the name of another nurse. Review of the video surveillance for 10/31/17 revealed LPN #4 missing from the building for periods of time as well as sleeping at the nurses' station. Staff reported they had to go out to her car to wake her up to give medications to residents. | F 684 | **F804**<br>1. Pureed consistency was addressed by CDM immediately on 11/28/17.<br>2. 100% audit of all residents on a pureed diet was completed on 11/28/17.<br>3. Dietary staff was re-educated on proper puree consistency staring on 11/28/17.<br>4. CDM to audit pureed meals 2x a week for 6 weeks. Any findings of noncompliance will be presented to the QAPI committee for review. | 11/28/17<br>11/28/17<br>11/28/17<br>01/26/18 |
| F 804 SS=D | Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility dietary department failed to prepare and serve pureed textured food in a manner to prevent comingling of the food on the plate for 1 of 4 meals observed.<br><br>The findings included:<br><br>Observation on 11/28/17 at 11:29 AM of the resident mid-day meal trayline service in the dietary department, with the Certified Dietary Manager (CDM) present, revealed the last several resident trays were being served on the trayline. Further observation revealed the pureed ham and beans, and the pureed cabbage were runny. Further observation of the pureed textured | F 804 | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 804 | Continued From page 26<br>food served on individual resident's plates revealed the pureed ham and beans and pureed cabbage ran together and comingled on the plate.<br><br>Interview with the CDM on 11/28/17 at 11:35 AM in the dietary department confirmed the pureed textured food was very runny and co-mingled on the plate. Further interview confirmed the pureed consistency was "...not to the proper standard..." | F 804 | | |